STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10L014	A. BUILDING _____ B. WING _____	C 02/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANDY PINES	11301 SE TEQUESTA TERRACE TEQUESTA, FL 33469

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 000	Initial Comments An unannounced complaint survey, CCR# 2019002831 was commenced on [redacted] and concluded on [redacted] at Sandy Pines, , Residential Treatment Facility. Two of four allegations were substantiated. The facility is not in compliance with 42 CFR Part 483, Subpart G, Requirements for Psychiatric Residential Treatment Facilities.	N 000		
N 189	POST INTERVENTION DEBRIEFINGS CFR(s): 483.370(b) Within 24 hours after the use of restraint or seclusion, all staff involved in the emergency safety intervention, and appropriate supervisory and administrative staff, must conduct a debriefing session that includes, at a minimum, a review and discussion of - 483.370(b)(1) The emergency safety situation that required the intervention, including discussion of the precipitating factors that led up to the intervention; This ELEMENT is not met as evidenced by: Based on review of the facility's own Policy and Procedure, record review and interview, the Psychiatric Residential Treatment Facility (PRTF) failed to have a debriefing within 24 hours with all staff involved in the emergency safety intervention for1 of 3 sampled residents (Resident #1). The findings included: Review of the facility's own policy titled,	N 189		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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N 189	Continued From page 1 "Seclusion and Restraint" effective . . . . . , revised on and reviewed , reveals evidence of documentation that within 24 hours post seclusion/restraint the staff involved in the intervention and the appropriate members of the treatment team will conduct a debriefing session. Review, on of Resident #1's record, reveals that the resident had a Restraint Order on that was initiated at 7:00 PM that ended at 7:01 PM. Further review of the restraint order/record revealed 1 of 2 staff members, Staff E, identified in the restraint did not participate in the debriefing for staff. During an interview on . . . . . at 10:44 AM, Staff "E" stated he does not recall if he debriefed with other staff members after the incident, as he is not assigned to that Unit, where Resident #1 was but intervened when he saw the residents "acting up."	N 189		
N 193	POST INTERVENTION DEBRIEFINGS CFR(s): 483.370(c) Staff must document in the resident's record that both debriefing sessions took place and must include in that documentation the names of staff who were present for the debriefing, names of staff who were excused from the debriefing, and any changes to the resident's treatment plan that result from the debriefings. This ELEMENT is not met as evidenced by: Based on review of the facility's own Policy and Procedure, record review and interview, the Psychiatric Residential Treatment Facility (PRTF) failed to document what staff were at the debriefing, who was excused and any changes to the resident's treatment plan that result from the	N 193		

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N 193	Continued From page 2 debriefings for 1 of 3 sampled residents reviewed for restraints (Resident #1). The findings included: Review of the facility's own policy titled, "Seclusion and Restraint" effective . . . . . , revised on and reviewed , reveals evidence of documentation that within 24 hours post seclusion/restraint the staff involved in the intervention and the appropriate members of the treatment team will conduct a debriefing session. Review, on of Resident #1's record, reveals that the resident had a Restraint Order on that was initiated at 7:00 PM that ended at 7:01 PM. Further review of the restraint order/record revealed 1 of 2 staff members, Staff E, identified in the restraint did not participate in the debriefing for staff. Continued review reveals there was no evidence of documentation as to why Staff "E" did not participate in the debriefing. During an interview on . . . . at 10:44 AM, Staff "E" stated he does not recall if he debriefed with other staff members after the incident, as he is not assigned to that Unit, where Resident #1 was but intervened when he saw the residents "acting up."	N 193		
N 198	MEDICAL TREATMENT FOR INJURIES CFR(s): 483.372(b)(1) A resident will be transferred from the facility to a hospital and admitted in a timely manner when a transfer is medically necessary for medical care or acute psychiatric care; This ELEMENT is not met as evidenced by:	N 198		

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N 198	Continued From page 3 Based on record review and interview, the Psychiatric Residential Treatment Facility (PRTF) failed to transfer a resident from the facility to a hospital in a timely manner for 1 of 3 sampled residents reviewed (Resident #1). The findings included: A review of Resident #1 file reveals Resident #1 was complaining of their arm "hurting" on [redacted] at 1:55 AM. On Sunday, [redacted], Resident #1's parent informed the facility's staff that the resident had limited range of motion in their arm. Further review reveals the facility's Nurse notified the physician and Resident #1's name was placed on the "medical board." Continued review reveals that on Monday, [redacted], the resident's parent called the facility stating that the resident cannot move their arm. Further review reveals that upon assessment, Resident #1 was not able to straighten their arm. Further review reveals that on Tuesday, [redacted], the Advanced Registered Nurse Practitioner came to the facility to assess Resident #1 and determined the resident needed to have a [redacted], the results of which documented the resident had a right upper arm fracture. Continued review reveals the resident was sent to the Hospital Emergency Room the following day, Wednesday, [redacted].	N 198		
N 208	FACILITY REPORTING CFR(s): 483.374(b)(2) In the case of a minor, the facility must notify the resident's parent(s) or legal guardian(s) as soon as possible, and in no case later than 24 hours after the serious occurrence.	N 208		

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N 208	Continued From page 4 This ELEMENT is not met as evidenced by: Based on record review and interview, the Psychiatric Residential Treatment Facility failed to notify a parent or guardian of a serious occurrence as soon as possible for 1 of 3 sampled residents (Resident #1). The findings included: A review of Resident #1 file reveals Resident #1 was complaining of their arm "hurting" on at 1:55 AM. On Sunday, , Resident #1's parent informed the facility staff that the resident had limited range of motion in their arm. Further review reveals the facility's Nurse notified the physician and Resident #1's name was placed on the "medical board." Continued review reveals that on Monday, , the resident's parent called the facility stating that the resident cannot move their arm. Further review reveals that upon assessment, Resident #1 was not able to straighten their arm. Continued review reveals that on Tuesday, , the Advanced Registered Nurse Practitioner came to the facility to assess Resident #1 and determined the resident needed to have a , , the results of which documented the resident had a right upper arm and the resident would be sent to the Emergency Room the following day, Wednesday, . There was no evidence of documentation that the resident's parent was notified on Tuesday, that an , was ordered, the results of the , and that the resident would be sent to the Emergency Room the following day, Wednesday, . Continued review reveals the resident's parent was notified the next day, Wednesday, at 8:11 AM.	N 208		

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N 208	Continued From page 5 During an interview on at 2:51 PM, Staff "G" states she wrote the "note" on at 8:19 AM for Staff "H" because she is a night nurse, it was getting late for her to leave and stated she notified Resident #1's parent of the and that the resident going to the Emergency Room that morning.	N 208		